“The agencies have been pummeled down”: A conversation with Dorit Reiss on the state of American public health

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13 April 2026

On April 9, 2026, the Washington Post *broke a story that crystallized what has been happening inside the Centers for Disease Control and Prevention (CDC) for more than a year. Acting CDC Director Jay Bhattacharya had blocked the publication of a completed agency report showing that the COVID-19 vaccine reduced emergency department visits and hospitalizations for healthy adults by roughly half during the 2025-26 winter season.*

The report had already cleared CDC's own internal scientific review. The methodology it used was identical to the one the agency applied to assess flu vaccine effectiveness—a study published in the CDC's flagship journal, the Morbidity and Mortality Weekly Report, *just one week earlier. That the same methodology was deemed acceptable for flu but suddenly problematic for COVID is not a neutral scientific judgment. It directly contradicts the public position that Kennedy's HHS and his reconstituted ACIP have staked out: that COVID vaccines offer insufficient benefit to warrant routine recommendation.*

Suppressing data on the grounds of “methodological concerns,” when those same methods were used without objection for an influenza study one week earlier, is not a credible defense. They are suppressing science to fit a predetermined political conclusion. Scientists familiar with the decision spoke to the Post *only under conditions of anonymity, citing fear of retaliation if they were identified.*

When contacted for this article following the interview, Professor Dorit Reiss addressed the suppression directly: withholding data that does not fit your predetermined conclusions is not transparency, she wrote, and the fact that a scientist was willing to speak up at all—only anonymously, out of apparent fear—speaks to how deeply unhappy researchers inside the agency have become with their leadership. The word “retaliation” tells you nearly everything you need to know about the state of American public health in the spring of 2026.

The suppression of that report is but the latest development in a systematic dismantling of the public health infrastructure that the United States spent more than a century building. Under Health and Human Services Secretary Robert F. Kennedy Jr., operating within the broader deregulatory agenda of the Trump administration, the machinery of evidence-based governance has been stripped, piece by piece, from the inside.

The Advisory Committee on Immunization Practices (ACIP), the independent expert body that has guided vaccine policy since 1964, was gutted in June 2025 when Kennedy fired all 17 sitting members—pediatricians, immunologists and infectious disease specialists—and replaced them with people qualified only by their ideological alignment with Kennedy’s own anti-vaccine wrecking operation. By January 2026, the reconstituted committee had been used to strip universal recommendation status from vaccines protecting against influenza, COVID-19, rotavirus, hepatitis A, hepatitis B and meningococcal disease, reducing the recommended childhood immunization schedule from 17 vaccine-preventable diseases to 11. A federal judge has since placed a legal hold on those changes, but the administration's response remains uncertain.

The consequences of this rollback are already visible in the disease data. The United States recorded 2,255 measles cases in 2025, the highest annual total since 1992, placing the country's measles elimination status, maintained since 2000, in jeopardy. Pertussis, or whooping cough, caused 28,783 infections and at least 13 deaths, primarily among unvaccinated infants. Meanwhile, COVID-19 continues to circulate at a scale that dwarfs other infectious threats: estimates from the Pandemic Mitigation Collaborative placed total SARS-CoV-2 infections in 2025 at roughly 260 million, with somewhere between 81,000 and 175,000 excess deaths attributable to the virus. Vaccination uptake for the 2025-26 COVID booster reached just 17.3 percent of adults by early January 2026.

The CDC itself has been hollowed out. Mass firings eliminated institutional memory and expertise that accumulated over decades. Scientists who remain report working in an environment where political pressure, not evidence, increasingly determines what gets published and what gets buried as the recent suppressed vaccine report makes plain.

This is the third conversation the World Socialist Web Site *has conducted with Professor Dorit Reiss, a law professor at UC Law San Francisco who specializes in vaccine policy, administrative law and public health law. In two previous interviews—in September and December 2025—Reiss mapped the legal architecture of the Kennedy agenda, explained how the capture of ACIP worked as a mechanism for dismantling vaccine policy without passing new legislation, and warned that the damage to public health institutions would not be easily reversed even if the political actors responsible were removed tomorrow.*

This interview was conducted on April 8, 2026. In it, Reiss assesses where things stand now: the legal fate of the ACIP, the implications of the administration's failure to nominate a permanent CDC director, the fragmentation of federal public health authority as states pull away from federal guidance, the Supreme Court's role in concentrating executive power over expert agencies, and what the absence of scientific leadership at the CDC and the Office of the Surgeon General means for the country's ability to respond to the health crises already under way.

The picture that emerges is of a public health system in deep, compounding crisis, one in which the damage is structural, the recovery will be long and difficult, and people most likely to pay the price are workers who can least afford to.

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Vaccines and of the Vaccines Working Group on Ethics and Policy and writes extensively on the legal and social dimensions of vaccination policy. This is the third interview the World Socialist Web Site *has conducted with Professor Reiss; the previous two were published in September 2025 and December 2025.*

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Great damage has already been done

Benjamin Mateus (BM): We are looking at a public health system in extremely deep crisis, not just operationally, but institutionally. It appears that Secretary Kennedy has been moving around the normal regulatory and advisory channels that would ordinarily constrain him, reshaping how decisions are made at HHS, the CDC and the ACIP. Where do you see things standing right now, and what do the next few months look like?

Dorit Reiss (DR): Let me start with what we already know and then address the things that are still in flux.

What we know is that our health agencies have been pummeled down, and they are not likely to recover anytime soon even if Kennedy is gone tomorrow. They were hurt first by losing enormous numbers of personnel. Institutional memory and expertise were lost, and those cannot be quickly restored. The agencies have also been hurt by funding cuts and by a fundamental change in their sense of mission. It used to be a norm that the FDA's policy direction was guided by politics to some degree, but its decisions on individual products were not. That is no longer true. The ACIP used to be constituted based on expertise, not ideological alignment. That is also no longer true. Our agencies are badly hurt, and fixing them will require time, possibly statutory intervention from Congress, and will be far from straightforward.

The second thing we know is that states are increasingly detaching themselves from the federal government on public health. I do not think that this can easily be reversed. The states that have distanced themselves from ACIP guidance are going to remain cautious about trusting a process that has proven so vulnerable. That means we will have far less centralized coordination and information sharing than we did before. States cannot license vaccines or pharmaceutical products on their own—there are limits to how far they can go—but where they can act independently, many of them will.

Third, we are going to see a real-world experiment unfold, with some states following the new skepticism toward vaccines and suffering corresponding outbreaks. Those outbreaks will not stay neatly within state borders; people travel. But I think we will see a clear pattern in which states that have weakened their public health frameworks see more cases and more preventable suffering.

What we do not yet know: Has the White House genuinely put constraints on Kennedy's actions? He has been relatively quiet on vaccines, but he also recently revised the ACIP charter, which suggests he still has room to maneuver. We do not know how the government will respond legally to the court challenge filed by the American Academy of Pediatrics and allied groups—whether it will appeal the judge's ruling and on what grounds. We do not know who will be nominated as the permanent CDC director. And more broadly, the dismantling of the administrative state itself, which goes well beyond vaccines, is going to have long-term implications that we are only beginning to understand.

BM: With respect to the legal issues now pending and the politicization of appointees at these public health institutions, can you speak to how a Supreme Court ruling might reshape the relationship between political appointees and expert agencies?

DR: This is a piece of administrative law that matters a great deal here. Over the last decade, the Supreme Court has significantly changed its approach to questions of who gets appointed to federal agencies, how they can be removed, and how much independence they can have from the president.

The traditional understanding was that Congress sets the terms for appointments and can place protections around agency experts … for example, by saying that the president may only remove certain officials for specific documented reasons, not simply because they disagree with the administration's agenda. The Supreme Court has been steadily closing off that option. The court's current position is that the president must be, in effect, the commanding officer of the entire administrative state, and that anything making it harder for the president to control appointees should be removed as a constitutional matter.

What this means practically is that it becomes very difficult to insulate experts from political pressure. If experts are going to operate without Senate confirmation, the legal logic now requires that political appointees have real authority over them. So even if Congress wanted to pass legislation protecting scientific independence at the CDC or FDA, the court's jurisprudence limits how effectively that protection can be structured. Experts are going to have a harder time acting independently of political leadership, and that means policies will be driven less by evidence and more by whoever is in power.

BM: In that sense, the days when scientific expertise was its own form of authority within these agencies are already over in important ways.

DR: Yes. And the point I want to make clearly is that one historically proposed solution to this kind of political interference—building in legal protections that make it harder to remove career scientists and experts—is precisely the avenue the Supreme Court is closing. We cannot protect the experts in the way we once could.

BM: I want to stay on the broader political context for a moment. The attacks on public health spending—Medicare, Medicaid, CDC and NIH grants, pandemic preparedness—seem connected to something larger than budget priorities alone. There is a logic here in which scientific expertise and public health investment become politically inconvenient.

DR: Public health has always been political. It must compete for public resources against other priorities, and that has always been true. But there is something else: public health is by its nature oriented toward the collective. The fundamental premise is that the health of the population matters, that everyone deserves access to protection. That is a political orientation. It is not neutral. And that makes it a natural target for those who do not share that orientation.

There is also a structural problem that makes public health hard to defend politically. When public health works well, nothing dramatic happens. The outbreaks that were prevented are invisible. So, you are either trying to justify investment during a period when things look fine—because the disasters were avoided—or you are defending your decisions in the middle of a crisis, when some things have inevitably gone wrong. That puts public health at a permanent political disadvantage.

And you are right that if you want to undercut public health and justify cutting its funding, you need to first undercut trust in science. You need to bring in voices that argue the experts cannot be trusted, that the data cannot be believed. That is the ideological work that figures like Kennedy have been doing. It creates the political permission structure for cuts that would otherwise be untenable.

BM: There is also a historical dimension here. George Washington required the Continental Army to be inoculated against smallpox precisely because disease destroyed military effectiveness. Public health and the ability to function as a society have always been deeply intertwined. The Civil War made sanitation and hygiene central to public health concerns more broadly in the evolving discipline. World War I and the 1918 influenza pandemic demonstrated how deeply interconnected global health and social conditions truly are.

DR: These are important historical points. During most wars before the 20th century, more soldiers died of disease than of enemy action. Public health was not a separate concern from military effectiveness; it was a precondition of it. The inoculation of Washington's army is one of the most consequential public health decisions in American history. The idea that public health and national security are somehow in competition is not only wrong—it is historically illiterate.

The vacancy at the Centers for Disease Control

BM: Where does the legal fight over the ACIP stand right now?

DR: The situation has developed significantly. A federal judge issued a stay, meaning a temporary legal hold, suspending enforcement of the challenged actions, on the administration's January 2026 memo restructuring the ACIP, and on the membership of 13 of the current 17 committee members. What that means in practice is that the ACIP cannot currently function in its reconstituted form, and everything the administration did to the vaccine schedule is legally on hold. The schedule that applies is the one that was in place at the end of May 2025.

There are two parallel legal tracks. One is the question of whether the government will appeal the judge's order. The other is that the underlying case is still moving forward; both sides are asking the judge to rule in their favor on the full merits of the dispute, so the legal battle is not over.

On the appeal question: there is a legal argument from the parties who brought the case—the American Academy of Pediatrics and allied medical groups, who in legal terms are called the plaintiffs, meaning the parties who initiated the lawsuit—that this type of court order may not be directly appealable. Courts have generally treated stays in situations like this similarly to preliminary injunctions, which can be appealed, so the government could likely appeal if it chooses to. There is a question about timing. If the order is treated as a stay, there is an argument that the government had only 10 days to appeal and has already missed that window. If treated more like a preliminary injunction, the government would have 60 days, and time may remain.

I think for the administration this is genuinely uncertain. Filing an appeal would generate news coverage on vaccines, which they have been trying to avoid in the run-up to the midterms. But leaving this decision uncontested sets a precedent limiting what the administration can do going forward. Kennedy almost certainly wants an appeal. Whether the White House agrees is a political calculation I cannot predict.

At the same time, a lawyer named Aaron Siri—who represents the Informed Consent Action Network, a prominent anti-vaccine legal organization—has filed a petition asking the secretary to amend the ACIP charter to remove the requirement that members have relevant scientific expertise. That expertise requirement was one of the bases on which the judge found the new appointments problematic. The administration recently filed a notice renewing the ACIP charter with some revisions to the membership language. Whether this is a step toward reconstituting the committee with a new slate of members—still ideologically anti-vaccine, but with different credentials—or simply a procedural maneuver, we do not yet know.

The practical consequence of all this uncertainty is that there is no functioning mechanism to update vaccine recommendations. If pharmaceutical companies want to bring out updated COVID boosters for the next season, the FDA will need to approve them, but there will be no current ACIP recommendation covering them. That creates real uncertainty for patients, providers and insurers.

BM: What about the vaccine injury compensation system? There have been moves to create new diagnostic codes for COVID vaccine injuries, and bills in Congress that would change liability protections for vaccine manufacturers. How do those pieces fit together?

DR: They are separate issues. Let me take them one at a time.

The ICD-10 codes—these are the standardized billing and diagnostic codes that doctors and hospitals use to record diagnoses—are managed through the World Health Organization with input from member countries, including the United States. Anti-vaccine groups have been pushing for new codes specifically for COVID-19 vaccine injuries. I am skeptical that this makes a lot of practical difference. Research on vaccine safety does not primarily rely on billing codes. The codes are not what drives liability determinations.

The more significant question is the Vaccine Injury Compensation Program, known as VICP. COVID-19 vaccines are not currently covered under VICP at all. They fall under a separate, narrower program called the Countermeasures Injury Compensation Program, which has much more limited benefits and harder eligibility requirements. For COVID vaccines to be added to VICP, Congress would need to act—specifically, it would need to impose an excise tax on COVID vaccines, which is how the program is funded. There is currently one bill proposing this, introduced by Senator Rand Paul, but it has not moved.

Paul's bill would also remove the liability protections that currently shield vaccine manufacturers from most personal injury lawsuits. A second bill from Representative Paul Gosar would do the same. This matters because the profit margins on vaccines are thin. If manufacturers faced unrestricted civil liability—meaning anyone who believed they were harmed could sue them directly in court—the financial risk might cause manufacturers to stop producing vaccines for the American market altogether. That appears to be an acceptable outcome to Kennedy, who would prefer fewer vaccines available. It would also benefit the lawyers who would bring those lawsuits, some of whom have long professional relationships with Kennedy.

There is a third potential bill under discussion that would address genuine structural problems in the VICP—adding more hearing officers to reduce backlogs, raising compensation caps that have not been updated since the 1980s, and similar reforms. I hope that bill does move, because people who have suffered genuine harm from vaccines deserve fair compensation, and the current system is not adequately serving them.

Surgeon General nomination held up

BM: And the nomination of Casey Means as Surgeon General?

DR: Stalled. My understanding is that the administration does not have the votes to move the nomination out of committee. President Trump signaled at one point that he was not deeply invested in it, though the White House subsequently said it was still supporting her. I doubt serious political capital will be spent on her behalf. For now, it appears her confirmation is going nowhere.

BM: What does the absence of a Surgeon General and a permanent CDC director say about the condition of public health in the United States right now?

DR: By themselves, unfilled positions are not necessarily catastrophic. The Surgeon General's role is primarily communicative—translating public health knowledge into public guidance and lending official authority to health warnings. The Surgeon General was the first official to warn Americans publicly about the dangers of smoking, for example. Not having that position filled means losing an important tool of communication. But I would rather have it vacant than filled by someone actively promoting misinformation.

The same is true of the CDC director. We have had acting-directors

before, and the agency has functioned. The deeper problem is not the vacancy itself—it is what the vacancy reflects. The reason these positions are unfilled is that the administration is trying to place people in them who are hostile to the scientific mission of the agencies, unqualified to lead them, or both. The vacancy is a symptom of that intention.

What worries me more than the empty chairs is the broader cultural and institutional damage. There is a sustained, coordinated effort to erode trust—not just in vaccines, not just in the CDC, but in science and expertise as such. When you systematically undermine confidence in public health institutions, you do not just discourage vaccine uptake. You break the social fabric that makes collective responses to health threats possible at all. And when you try to communicate with people who have been fed a different set of facts—a different reality—finding common ground becomes genuinely difficult.

BM: That erosion of common ground may be the most serious long-term consequence of all this.

DR: I think that is right. There are a lot of well-meaning people who have been led in this direction because they have been fed false information convincingly. They are not bad people. They want everyone to be healthy. But when we are working from different facts, communication itself breaks down. That is a serious problem, and it will not be solved quickly.